POSTPARTUM HOME VISIT SUMMARY

MOTHER'S INFORMATION

Patient Name:		Medicaid #:	DOB:	Age: Race:
Delivery Date:	Type of Delivery:	Delivery Time:	Gest Age @ Delivery:	Hospital D/C Date:
Address:				County:
Phone Number:		Alternate Phone Number:		
Directions to Home:				

REASON FOR HOME VISIT

(Check all that apply)

___Under 16 years of age ___ Birth weight
___Drugs and Alcohol ___Other: (specify)
___Missed hospital encounter ___ Partner Abuse
___Mental Illness ___ No Home Visit Needed

VISIT ATTEMPTS

Date Type of Attempt

_____
_____
_____
_____

PSYCHOSOCIAL ASSESSMENT

Problems/Issues	YES	NO	Comments
Poor previous parenting experience			
Poor support system			
Literate			
Areas of anxiety noted			
Drugs, Alcohol, Tobacco Usage			
Conflict/ Violence noted in home			
Appropriate newborn/mother attachment			
Support systems present			
Mother able/willing to provide needed infant care			
Father able/willing to provide needed infant care			
Emotional status (Tearful, moody, anxious, depressed)			
Fatigue/Exhaustion			
Sleep disturbances			
Adequate living arrangements			
Other areas of need			
Referrals made			

PHYSICAL ASSESSMENT

Temperature:	BP:		Pulse:	Respirations:
Problems	**Yes**	**No**	**Comments**	
Breasts				
Perineum				
Lochia				
Abdomen (fundus)				
Incision site (signs of infection)				
Edema (location)				
Respiratory status				
Pain				
Appetite/Fluid intake				
Bladder/Bowel Function				

EDUCATION/COUNSELING

Teaching (Check areas discussed/or pamphlets given)
___Breast Care ___Breast Feeding ___Perineum Care ___Hygiene ___Nutrition ___Incision Care ___Bathing
___Family Planning/Birth Control ___Sexual Relations ___Educational Materials/Pamphlets provided ___Other
Comments:

SAFETY ASSESSMENT

___Workable Smoke Detector ___Car Seat Available/Used ___Inside Pets ___Crib Safety ___Telephone ___ Refrigeration ___Adequate Cooling ____ Adequate Heating ___ Vermin infestation
Comments:

Visiting Nurse Signature:	**Date of Visit:**

POSTPARTUM HOME VISIT SUMMARY

INFANT INFORMATION

Infant name:	___Male ___Female	Birth complications:	
Birth weight:	Current weight:	___Bottle fed ___Breast fed	___Tolerates Feedings
Formula: ___Ounces every ____Hour ___ Ounces Water per day ___ Wet Diapers per day ___Stools per day			
Medications:			
Pediatric Provider:			

INFANT PHYSICAL ASSESSMENT

Temperature:	**Heart rate:**	**Respiratory rate:**

Problems		**Yes**	**No**	**Comments**
Skin: membranes	Pink nail beds/Mucous			
	Jaundice			
	Rash			
	Other			
Neurological:	Lethargic			
	Hyper/Hypotonic			
	Crying (high pitched, non-consoling)			
	Symmetrical eye movement			
	Other			
Cardiovascular:	Tachycardia/Bradycardia			
	Irregular heart rate			
	Other			
Respiratory:	Rales/Rhonchi			
	Cough (dry, productive, etc.)			
	Nasal drainage (color, consistency)			
	Other			
Gastrological:	Abdominal distention			
	Other			
Genitourinary:	Abnormal genitalia			
	Circumcision			

	Other			
Extremities:	Adequate bilateral hand grasp			
	Hip click (right or left)			
	Other			

EDUCATION COUNSELING

Teaching: (Check areas discussed or pamphlets provided)			
___General Infant Care (bathing, diapering, napping/sleeping position, holding) ___Colic ___Thermometer use ___Danger signs			
___Basic Home Safety	___When to call the Doctor	___Normal Growth and Development	___Day Care

Mother's Post Partum Appointment/Date and Time:	**Location:**	**Mother aware:**
Infant's next Pediatric Provider Appointment:	**Location:**	**Mother aware:**
Other Appointments/Referrals Mother or infant:		

Comments/Address Reason for Home Visit:_____

Visiting Nurse Signature:	**Date of Visit**